g. Electric hospital beds are purchased or rented only in the following circumstances: (10-31-89)

i. The physician certifies that the recipient's medical condition is such that he is unable to operate a manual hospital bed; and (10-31-89)

ii. The client is unable to change position as needed without assistance; and (10-22-93)

iii. The recipient resides in an independent living situation where there is no one to provide assistance with a manual bed for the major portion of the day. (10-31-89)

h. Continuous positive airway pressure (CPAP) machines are purchased or rented only in the following circumstances: (10-29-92)

i. The physician certifies that the recipient's diagnosis is obstructive sleep apnea, which is supported by documentation of at least thirty (30) episodes of apnea, each lasting a minimum of twenty (20) seconds during six (6) to seven (7) hours of recorded sleep; and (10-29-92)

ii. Surgery is a likely alternative. (10-29-92)

i. Bilevel positive airway pressure (BiPAP) are purchased or rented only in the following circumstances: (10-22-93)

i. A CPAP machine has been proven ineffective in treating obstructive sleep apnea;and (10-22-93)

ii. Used in place of a ventilator. (10-22-93)

04. Program Requirements -- Medical Supply Items. The Department will purchase a one (1) month supply of necessary medical supplies for the treatment or amelioration of a medical condition identified by the attending physician in an amount not to exceed one hundred dollars ($100) per month without prior authorization. Any combination of one (1) month's worth of supplies greater than one hundred dollars ($100) requires prior authorization. Each of the claims for the preceding must contain all information required in Subsection 106.01. The prior authorization period will be established by the Department following receipt of a physician's order and medical justification. (10-22-93)

a. Covered supplies are limited to the following: (11-1-86)

i. Catheter supplies including catheters, drainage tubes, collection bags, and other incidental supplies; and (11-1-86)

ii. Cervical collars; and (11-1-86)

iii. Colostomy and/or urostomy supplies; and (11-1-86)

iv. Disposable supplies necessary to operate Department approved medical equipment such as suction catheters, syringes, saline solution, etc.; and (11-1-86)

v. Dressings and bandages to treat wounds, burns, or provide support to a body part; and (11-1-86)

vi. Fluids for irrigation; and (11-1-86)

vii. Incontinence supplies (See Subsection 106.04.c. for limitations); and (10-22-93)

viii. Injectable supplies including normal saline and Heparin but excluding all other prescription drug items; and (10-31-89)

ix. Blood glucose or urine glucose checking/monitoring materials (tablets, tapes, strips, etc.); and (10-31-89)

x. Therapeutic drug level home monitoring kits. (10-31-89)

b. Oral, enteral, or parenteral nutritional products of any amount must be prior authorized by the Department. The Department will only consider authorization under the following circumstances: (10-1-91)

i. A nutritional plan shall be developed and be on file with the Department and shall include appropriate nutritional history, the recipient's current height, weight, age and medical diagnosis. For recipients under the age of twenty-one (21), a growth chart including weight/height percentile shall be included; (10-1-91)

ii. The plan shall include goals for either weight maintenance and/or weight gain and shall outline steps to be taken to decrease the recipient's dependence on continuing use of nutritional supplements; (10-1-91)

iii. Documentation of evaluation and updating of the nutritional plan and assessment by a physician periodically as determined by the Department. (10-22-93)

c. Limitations. (10-22-93)

i. Incontinet supplies are covered for persons over four (4) years of age only. (10-22-93)

ii. Disposable diapers are restricted in number to: Two hundred forty (240) per month for child's briefs; and one hundred eighty (180) per month for adult's briefs. Effective October 1, 1993, if the physician documents that additional briefs are medically necessary, the Department may authorize additional amounts on an individual basis. (12-3-93)

iii. Disposable underpads are restricted to 150 per month. (10-22-93)

05. Program Abuse. The use or provision of DME/medical supply items to an individual other than the recipient for which such items were ordered is prohibited. Violators are subject to penalties for program fraud and/or abuse which will be enforced by the Department. The Department shall have no obligation to repair or replace any piece of durable medical equipment that has been damaged, defaced, lost or destroyed as a result of neglect, abuse, or misuse of the equipment. Recipients suspected of the same shall be reported to the SUR/S committee. (10-22-93)

06. Billing Procedures. The Department will provide billing instructions to providers of DME/medical supplies. When prior authorization by the Department is required, a copy of the authorization letter must be attached to the claim form when submitted. (11-1-86)

07. Fees and Upper Limits. The Department will reimburse according to Subsection 060.04., Individual Provider Fees. (12-31-91)

107. OXYGEN AND RELATED EQUIPMENT. MA will provide payment for oxygen and oxygen-related equipment based upon the Department's fee schedule. Such services are considered reasonable and necessary only with recipients with significant hypoxemia. In addition, providers must be eligible for Medicare program participation prior to the issuance of a Medicaid provider number. (11-1-86)

01. Medical Documentation. Oxygen and related equipment are provided only upon the written order of a physician. Once received, such orders will remain in effect for one (1) year and must contain at least the following: (11-1-86)

a. A diagnosis of the disease requiring home oxygen use; and (11-1-86)

b. The flow rate and oxygen concentration; and (11-1-86)

c. An estimate of the frequency and duration of use. A prescription of "oxygen PRN" or "oxygen as needed" is not acceptable. (11-1-86)

d. Request for home use oxygen must contain the laboratory evidence prescribed in Subsection 107.02. (5-1-92)

i. Age zero (0) to six (6) months of age require physician orders ONLY. (10-22-93)

ii. Age seven (7) months to twenty (20) years of age require letter of authorization from the EPSDT Program Coordinator as being "medically necessary" if lab studies and MD order are not provided which meet program requirements of Section 107.02. (10-22-93)

iii. Age twenty-one (21) or older require lab studies and physician orders. No preauthorization is required. (10-22-93)

e. A portable oxygen system may be covered to complement a stationary system if necessary, or by itself, to provide oxygen for use during exercise by a recipient with exercise-induced hypoxemia. To be considered, a request for a portable oxygen system must include: (10-22-93)

i. A description of the activities or exercise routine that a recipient undertakes on a regular basis which requires a portable oxygen system in the home; and (11-1-86)

ii. A description of the medically therapeutic purpose to be served by the portable system that cannot be served by a stationary system; and (11-1-86)

iii. Documentation that the use of the portable system results in clinical improvement in the recipient's condition. (11-1-86)

02. Laboratory Evidence. Initial claims for oxygen therapy must include: (11-1-86)

a. The results of a blood gas study as evidence of the need of administration of oxygen in the home. This may be either a measurement of the partial pressure of oxygen (PO2) in arterial blood or a measurement of arterial oxygen saturation obtained by oximetry. Because of the potential for conflict of interest, the results of arterial blood gas and/or oxygen saturation tests conducted by the oxygen supplier cannot be used to establish the recipients need for home oxygen. This restriction applies to the suppliers' employee, its corporated officers, or any associated or related organization. The results must come from tests conducted by a provider who will not benefit financially from a finding of coverage for home oxygen services; and (10-22-93)

b. The condition under which the studies are performed must be stated, i.e., at rest, while sleeping, while exercising, on room air, or if while on oxygen the amount, body position during testing, and similar information necessary for interpreting the evidence; and (11-1-86)

c. Laboratory evidence of the need for oxygen therapy due to significant hypoxemia will be considered to exist in the following circumstances: (5-1-92)

i. An arterial PO2 at or below 55 mmHg or an arterial oxygen saturation at or below eighty-eight percent (88%), taken at rest, breathing room air; or (5-1-92)

ii. An arterial PO2 at or below 55 mmHg or an arterial oxygen saturation at or below eighty-eight percent (88%) taken during sleep for a patient who demonstrates an arterial PO2 at or above 56 mmHg, or an arterial oxygen saturation at or above eighty-nine percent (89%) while awake or greater than normal fall in oxygen level during sleep (a decrease in arterial PO2 more than 10 mmHg or a decrease in arterial oxygen saturation more than five percent (5%)) associated with symptoms or signs reasonably attributable to hypoxemia, i.e., impairment of cognitive processes and nocturnal restlessness or insomnia. In either of these cases, coverage is provided only for nocturnal use of oxygen; or (5-1-92)

iii. If during exercise it is demonstrated that the oxygen saturation level falls below eighty-eight percent (88%), supplemental oxygen will be provided during exercise if there is evidence that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the patient was breathing room air. (5-1-92)

d. Coverage is provided for patients whose arterial PO2 is at or above 56 mmHg or whose arterial blood oxygen saturation is at or above eighty-nine percent (89%) if there is: (10-22-93)

i. Dependent edema suggesting congestive heart failure; or (11-1-86)

ii. "P" pulmonale on EKG (P wave greater than 3 mm in standard leads II, III, or AVF); or (11-1-86)

iii. Erthrocythemia with a hematocrit greater than fifty-six percent (56%). (11-1-86)

03. Service Exclusions. Payment is excluded in the following circumstances: (11-1-86)

a. Recipients with angina pectoris in the absence of hypoxemia; and (11-1-86)

b. Recipients who experience breathlessness without corpulmonale or evidence of hypoxemia; and (11-1-86)

c. Recipients with severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities; and (11-1-86)

d. Recipients with terminal illnesses that do not affect the lungs. (11-1-86)

04. Recipients Currently Receiving Home Oxygen. The Department will continue to pay for existing oxygen services for no more than twelve (12) months after the effective date of this Section. Continuation of such oxygen and supplies after that time period will be dependent upon the receipt of documentation of the need for oxygen as specified in Subsections 107.01. and 107.02. (12-31-91)

05. Cost Considerations. The Department will work with the physician, provider, and recipient to provide payment for the most cost-effective oxygen system that will meet the recipient's medical needs. (11-1-86)

108. AUDIOLOGY SERVICES. The Department will pay for audiometric services and supplies in accordance with the following guidelines and limitations: (10-1-91)

01. Audiology Examinations. When specifically ordered by a physician, all recipients are eligible for audiometric examination and testing once in each calendar year. Basic audiometric testing by certified audiologists and/or licensed physicians will be covered without prior approval. (10-1-91)

02. Additional Testing. Any hearing testing beyond the basic comprehensive audiometry and impedence testing must be ordered in writing before the testing is done. A copy of the physician's order must be attached to the claim for payment. (10-1-91)

03. Hearing Aids. The Department will cover the purchase of one (1) hearing aid per recipient with the following requirements and limitations: (10-1-91)

a. All hearing aid purchases require prior authorization from the Department. (10-22-93)

b. The following information shall be included with the request for preauthorization: the recipient's diagnosis, prognosis, the results of the basic comprehensive audiometric exam which includes pure tone, air and bone conduction, speech reception threshold, most comfortable loudness, discrimination and impedence testing, the brand name and model type needed. (10-22-93)

c. Covered services included with the purchase of the hearing aid include proper fitting and refitting of the ear mold and/or aid during the first year, instructions related to the aid's use, and extended insurance coverage for two (2) years. (10-22-93)

d. The following services may be covered in addition to the purchase of the hearing aid without prior authorization: batteries purchased on a monthly basis, follow up testing, necessary repairs resulting from normal use after the second year and the refitting of the hearing aid or additional ear molds no more often than forty-eight (48) months from the last fitting; (10-22-93)

e. Lost, misplaced, stolen or destroyed hearing aids shall be the responsibility of the recipient. The Department shall have no responsibility for the replacement of any hearing aid. In addition, the Department shall have no responsibility for the repair of hearing aids that have been damages as a result of neglect, abuse or use of the aid in a manner for which it was not intended. (10-1-91)

04. Payment Procedures. The following procedures shall be followed when billing the Department: (10-1-91)

a. The Department will only pay the hearing aid provider for an eligible Medicaid recipient if a properly completed claim is submitted to the Department within the one (1) year billing limitation. (10-22-93)

b. Payment will be based upon the Department's fee schedule (See Subsections 060.04.and 060.05.). (12-31-91)

05. Limitations. The following limitations shall apply to audiometric services and supplies: (10-1-91)

a. Hearing aid selection is restricted to the type and model which the Bureau has prior approved. (10-22-93)

b. Follow up services are included in the purchase of the hearing aid for the first two (2) years including, but not limited to, repair, servicing and refitting of ear molds. (10-22-93)

c. Providers are required to maintain warranty and insurance information on file on each hearing aid purchased from them by the Department and are responsible for exercising the use of the warranty or insurance during the first year following the purchase of the hearing aid; (10-1-91)

d. Providers shall not bill recipients for charges in excess of the fees allowed by the Department for materials and services; (10-1-91)

e. Audiology services will be a benefit for EPSDT eligible recipients under the age of twenty-one (21) (See Section 100.). (12-31-91)

109. (RESERVED).

110. LABORATORY AND RADIOLOGY SERVICES. (7-1-93)

01. Qualifications. Laboratories in a physician's office or a physician's group practice association, except when physicians personally perform their own patients' laboratory tests, must be certified by the Idaho Bureau of Laboratories and be eligible for Medicare certification for participation. All other Idaho laboratories must fulfill these requirements. (2-15-86)

02. Payment Procedures. Payment for laboratory tests can only be made to the actual provider of that service. An exception to the preceding is made in the case of an independent laboratory that can bill for a reference laboratory. A physician is not an independent laboratory. (2-15-86)

a. The payment level for clinical diagnostic laboratory tests performed by or personally supervised by a physician will be at a rate established by the Department that is no higher than Medicare's fee schedule. The payment level for other laboratory tests will be a rate established by the Department. (2-15-86)

b. The payment level for clinical diagnostic laboratory tests performed by an independent laboratory will be at a rate established by the Department that is no higher than Medicare's fee schedule. The payment level for other laboratory tests will be at a rate established by the Department. (2-15-86)

c. The payment level for clinical diagnostic laboratory tests performed by a hospital laboratory for anyone who is not an inpatient will be at a rate established by the Department that is no higher than Medicare's fee schedule as described in Section 085. The payment level for other laboratory tests will be at a rate established by the Department. (12-31-91)

d. Collection fees for specimens drawn by veinpuncture or catheterization are payable only to the physician or laboratory who draws the specimen. (2-15-86)

111. -- 113. (RESERVED).

112. REHABILITATIVE SERVICES - - MENTAL HEALTH. Pursuant to 42 CFR 440.130(d), the department shall purchase rehabilitative services for maximum reduction of mental disability and restoration of the recipient to the best possible functional level. Services shall be provided through the State Mental Health Authority in each region, hereafter referred to as the Community Support Program (CSP), in accordance with Title 39, Chapter 31, Idaho Code, Regional Mental Health Services. Each region shall deliver a range of Community Support Program (CSP) services in their communities including treatment, rehabilitation and supportive services. (7-1-94)T

01. Responsibilities of Regions. Each region shall enter into a provider agreement with the Division of Welfare for CSP services and shall be responsible for the following: (7-1-94)T

a. Develop, maintain and coordinate a region-wide, comprehensive and integrated service system of department and providers. (7-1-94)T

b. Provide CSP services directly, or through contracts with providers. (7-1-94)T

c. Assure provision of CSP services to recipients on a twenty-four (24) hour basis. (7-1-94)T

d. Assure completion of an intake assessment and service plan for each recipient. (7-1-94)T

e. Provide service authorizations and functions required to administer this section. (7-1-94)T

f. Monitor the quality of services provided in this section in coordination with the Divisions of Welfare and Family and Community Services. (7-1-94)T

02. Service Descriptions. A CSP shall consist of the following services: (7-1-94)T

a. A comprehensive assessment shall be completed for each recipient of CSP services which addresses the recipient's assets, deficits and needs directed towards formulation of a written diagnosis and treatment plan. Assessment is an interactive process with the maximum feasible involvement of the recipient. The assessment and supplemental psychiatric and psychological evaluations and tests, or specialty evaluations must be in written form, dated and signed to certify when completed and by whom, and retained in the recipient's file for documentation purposes. Should the assessment reveal that the person does not need rehabilitative services, appropriate referrals shall be made to meet other needs of the recipient. The assessment is reimbursable if conducted by a qualified provider, in accordance with 112.04.a through f. All the following areas must be evaluated and addressed: (7-1-94)T

i. Psychiatric history and current mental status which includes at a minimum, age at onset, childhood history of physical or sexual abuse, number of hospitalizations, precursors of hospitalizations, symptoms of decompensation that the recipient manifests, the recipient's ability to identify his symptoms, medication history, substance abuse history, history of mental illness in the family, current mental status observation, any other information that contributes to the recipient's current psychiatric status; and (7-1-94)T

ii. Medical history and current medical status which includes at a minimum, history of any major non-psychiatric illnesses, surgeries, hospitalizations, dates of last physical, dental, or eye examinations, pertinent family history of medical illness, current health problems/needs, current medications, name of current physician; and (7-1-94)T

iii. Vocational status which includes at a minimum, current and past job status, level of satisfaction with the vocation, educational level, military status, strengths and barriers to employment; and (7-1-94)T

iv. Financial status which includes at a minimum, adequacy and stability of the recipient's financial status, difficulties the recipient perceives with it, resources available, recipient's ability to manage personal finances; and (7-1-94)T

v. Social relationships/support which includes at a minimum, recipient's ability or desire to carry out family roles, recipient's perception of the support he receives from his family, role the family plays in the recipient's mental illness; and (7-1-94)T

vi. Family status which includes at a minimum, current living situation and level of satisfaction with the arrangement, present situation as appropriate to the recipient's needs; and (7-1-94)T

vii. Basic living skills which includes at a minimum, recipient's ability to meet basic living needs, what the recipient wants to accomplish in this area; and (7-1-94)T

viii. Housing which includes at a minimum, current living situation and level of satisfaction with the arrangement, present situation as appropriate to the recipient's needs; and (7-1-94)T

ix. Community/Legal status which includes at a minimum, legal history with law enforcement, transportation needs, supports the recipient has in the community, daily living skills necessary for community living. (7-1-94)T

b. A written service plan shall be developed and implemented for each recipient of CSP services as a vehicle to address the rehabilitative needs of the recipient. To the maximum extent possible, the development of a service plan shall be a collaborative process involving the recipient, his family or other support systems. The written service plan shall be developed within thirty (30) calendar days from the date the recipient chooses the agency as his provider. Case planning is reimbursable if conducted by a qualified provider, in accordance with 112.04.a through f. The case plan must include, at a minimum: (7-1-94)T

i. A list of focus problems identified during the assessment; and (7-1-94)T

ii. Concrete, measurable goals to be achieved, including time frames for achievement; and (7-1-94)T

iii. Specific objectives directed toward the achievement of each one of the goals; and (7-1-94)T

iv. Documentation of participants in the service planning; the recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient; and (7-1-94)T

v. Reference to any formal services arranged, including specific providers where applicable; and (7-1-94)T

vi. Planned frequency of services initiated. (7-1-94)T

c. Individual, group and family psychotherapy shall be provided in accordance with the objectives specified in the written service plan. (7-1-94)T

i. These services are reimbursable if provided by a qualified psychiatrist, physician, or CSP clinician, in accordance with 112.04.a through e. (7-1-94)T

ii. Family psychotherapy must include the recipient and one (1) family member at any given time and must be delivered in accordance with objectives as specified in the written service plan. (7-1-94)T

d. Pharmacologic management services shall be provided in accordance with the service plan. (7-1-94)T

i. Medication prescription must be done by a licensed physician or licensed nurse practitioner in direct contact with the recipient. (7-1-94)T

ii. Licensed and qualified nursing personnel can supervise, monitor, or administer medications within the limits of the Nurse Practice Act, Section 54-1402 (d), Idaho Code. (7-1-94)T

iii. Other CSP providers, included in 112.04, may assist in "self" administration by verbal prompts. (7-1-94)T

e. Individual Psychosocial Rehabilitation shall be provided in accordance with the objectives specified in the service plan. The service

plan goal is to aid recipients in work or school problems related to their mental illness, in obtaining skills to live independently or in preventing movement to a more restrictive living situation from independent living. Independent living is defined as a living situation, whether the recipient is living alone or with others, where there is no supervision by the owner or management of the facility. Individual psychosocial rehabilitation is reimbursable if provided by personnel of the region or an agency contracting with the region for CSP services and if the employee is a qualified provider, in accordance with 112.04. This service includes the following: (7-1-94)T

i. Assistance in gaining and utilizing skills necessary to undertake school or employment. This includes helping the recipient learn personal hygiene and grooming, securing appropriate clothing, time management and other skills related to recipient's psychosocial condition. (7-1-94)T

ii. Ongoing, on-site assessment/evaluation/feedback sessions to identify symptoms or behaviors and to develop interventions with the recipient and employer or teacher. (7-1-94)T

iii. Individual interventions in social skill training to improve communication skills and facilitate appropriate interpersonal behavior. (7-1-94)T

iv. Problem solving, support, and supervision related to activities of daily living to assist recipients to gain and utilize skills related to, personal hygiene, household tasks, transportation utilization, and money management. (7-1-94)T

vi. To assist the acquisition of necessary services when recipients are unable to obtain them by escorting them to medicaid reimbursable appointments. (7-1-94)T

f. Group psychosocial rehabilitation shall be provided in accordance with the objectives specified in the service plan. This is a service to two or more individuals, at least one of whom is a recipient, who are concurrently receiving a service which is identified in this section as group therapy. The service plan goal is to aid recipients in work or school problems related to their mental illness, in obtaining skills to live independently or in preventing movement to a more restrictive living situation from independent living. Group psychosocial rehabilitation is reimbursable if provided by personnel of the region or an agency contracting with the region for CSP services and if the employee is a qualified provider, in accordance with 112.04. This service includes: (7-1-94)T

i. Medication education groups provided by a licensed physician or licensed nurse focusing on educating recipients about the role and effects of medications in treating symptoms of mental illness. These groups must not be used solely for the purpose of group prescription writing. (7-1-94)T

ii. Employment or school related groups to focus on symptom management on the job or in school, anxiety reduction, and education about appropriate job or school related behaviors. (7-1-94)T

iii. Groups in communication and interpersonal skills, the goals of which are to improve communication skill and facilitate appropriate interpersonal behavior. (7-1-94)T

iv. Symptom management groups to identify symptoms of mental illnesses which are barriers to successful community integration, crisis prevention, identification and resolution, coping skills, developing support systems and planning interventions with teachers, employers, family members and other support persons. (7-1-94)T

v. Groups on activities of daily living which help recipients learn skills related to, but not limited to, personal hygiene and grooming, household tasks, transportation utilization and money management. (7-1-94)T

g. Community crisis support which includes intervention for recipients in crisis situations to ensure the health and safety or to prevent hospitalization or incarceration of a recipient. (7-1-94)T

i. A crisis may be precipitated by loss of housing, employment or reduction of income, risk of incarceration, risk of physical harm, and family altercation. (7-1-94)T

ii. Community crisis support may be provided prior to or after the completion of the assessment and service plan. Service is reimbursable if there is documentation that supports the need for the service, even if it is not in the service plan. (7-1-94)T

iii. Community crisis support is reimbursable if provided by personnel of the region or an agency contracting with the region for CSP services and if the employee is a qualified provider, in accordance with 112.04. (7-1-94)T

03. Excluded Services. (7-1-94)T

a. Treatment services rendered to recipients residing in inpatient medical facilities including nursing homes or hospitals. (7-1-94)T

b. Recreational therapy which includes activities which are primarily social or recreational in nature; (7-1-94)T

c. Job-specific interventions, job training and job placement services which includes helping the recipient develop a resume, applying for a job, and job training or coaching; (7-1-94)T

d. Staff performance of household tasks and chores. (7-1-94)T

e. Targeted Case Management as provided under the State Plan. (7-1-94)T

f. Any other services not listed in 112.02. (7-1-94)T

04. Community Support Program Provider Staff Qualifications. All individual providers must be employees of the State Mental Health Authority in each region or employees of an agency approved by the Department to provide Community Support services. The employing entity shall supervise individual CSP providers and assure that the following qualifications are met for each individual provider: (7-1-94)T

a. A physician shall be licensed in accordance with Title 54, Chapter 18, Idaho Code to practice medicine; (7-1-94)T

b. A nurse shall be licensed in accordance with Title 54, Chapter 14, Idaho Code; (7-1-94)T

c. A psychologist shall be licensed in accordance with Title 54, Chapter 23, Idaho Code; (7-1-94)T

d. A CSP clinician shall be employed by a state agency and meet the minimum standards established by the Idaho Personnel Commission. (7-1-94)T

e. A social worker shall hold a license in accordance with Title 54, Chapter 32, Idaho Code; (7-1-94)T

f. A CSP psychosocial rehabilitation specialist shall hold a bachelor's degree in a behavioral science such as social work, psychology,